March 9, 2006

CONTRACT
BETWEEN
_____(Area Authority/County Program)
AND
(PROVIDER Corporate Name)
A PROVIDER OF MH/DD/SA
STATE FUNDED SERVICES

THIS CONTRACT is made between _____ (herein known as the Area Authority/County Program"), and _____, (herein known as the "Provider"), operating under the laws of North Carolina. By means of this Contract, the Area Authority/County Program is establishing a relationship with Providers of State Funded services.

RECITALS

The Area Authority/County Program and the Provider enter into this Contract to govern Provider's provision of mental health, developmental disabilities and substance abuse services to individuals referred to it by the Area Authority/County Program.

Area Authority/County Program initially screens individuals seeking or needing mental health developmental disabilities and/or substance abuse services and refers to Provider participants.

Individuals covered by State Funds who are in need of mental health, developmental disability and/or substance abuse services choose providers for their services from a list of provider participants endorsed by the Area Authority/County Program.

Provider represents that it is a qualified provider of one or more mental health, developmental disabilities and/or substance abuse services.

This Contract sets forth provisions pursuant to which Provider will provide mental health, developmental disabilities and substance abuse services to individuals who have chosen Provider for such services.

NOW, THEREFORE, the Parties agree as follows:

Provider will provide mental health, developmental disabilities and/or substance abuse services to individuals who have chosen Provider for such services pursuant to and in compliance with the provisions of this Contract. Area Authority/County Program will provide access to such services to individuals, as well as quality assurance and monitoring relating to such services pursuant to and in compliance with this Contract.

ARTICLE I
RIGHTS AND OBLIGATIONS OF THE AREA AUTHORITY/COUNTY PROGRAM

1.0 Operations Manual. The Area Authority/County Program shall make available to the Provider a copy of the "Operations Manual". The Provider acknowledges receipt of the Operations Manual by signing this Contract. If the terms of this Contract conflict with information contained in the Operations Manual, the terms of the Contract shall control.

1.1 Notification of Applicable Regulations. The Area Authority/County Program shall make available to Provider copies of or access to all pertinent rules, regulations, standards, and other information distributed by the Department of Health and Human Services (DHHS) that are necessary for Provider's performance under the terms of this Contract. It is Provider's responsibility to access that information. The Area Authority/County Program shall notify Provider of any substantive change in rule or regulation as soon as possible after receipt of the information from the DHHS. A list of rules and regulations is part of the Operations Manual.

1.2 Monitoring Under Standards. The Area Authority/County Program shall be given full opportunity by Provider to review performance indicators on-site to evaluate compliance with the rules of the North Carolina Commission for Mental Health, Developmental Disability, and Substance Abuse Services (the "Commission"), the Secretary of the Department of Health and Human Services, and applicable law. The Area Authority/County Program has the authority to conduct local monitoring to evaluate compliance with Federal, DHHS, and other applicable rules and statutes (see Operations Manual) and Provider shall cooperate with Area Authority/County Program in such monitoring. The frequency and the intensity of the local monitoring will be at the discretion of the Area Authority/County Program.

1.3 Informed Choice of Provider. The Area Authority/County Program provides information to individuals covered by State Funds regarding their choice of Providers. The information includes names, contact information and locations of all Providers. Individual Providers whose relationship is terminated with a Provider organization, and who becomes an employee of another Provider organization, and/or who opens a private practice, shall notify individuals verbally and in writing of each individual's freedom of choice to continue receiving services from the same individual Provider, or to receive assistance from the Area Authority/County Program in learning about and/or selecting another Provider. The Provider shall follow the guidelines included in the Operations Manual for informing individuals in these circumstances.

1.4 Screening, Triage and Referral. The Area Authority/County Program will work with community agencies to ensure that individuals can enter the system through many avenues in order to receive timely and effective service. Individuals seeking access to services shall have an initial screening and triage by the Area Authority/County

Program (or its contract agent) in order to determine if a MH/DD/SA need exists. The Area Authority/County Program ensures appropriate disposition. The Screening, Triage & Referral (STR) staff will complete an initial screening and the STR staff will then contact the provider of choice or (in the absence of consumer preference) an appropriate provider who represents an appropriate consumer-provider match to complete a comprehensive diagnostic assessment. When necessary, TTY capability, for persons who have a hearing impairment, and foreign language interpretation will be provided to the person making the referral or to the individual seeking service for the purposes of receipt of appropriate information for referral of services at no cost when necessary.

ARTICLE II
RIGHTS AND OBLIGATIONS OF PROVIDERS OF STATE FUNDED SERVICES

2.0 Covered Services. Provider agrees to provide to individuals eligible for such services the covered services identified in Attachment A and all addenda in accordance with all requirements set forth or referenced in the Operations Manual and all subsequent revisions.

2.1 Maintenance of Facility Licensure, Accreditation and Credentialing. Provider and its agents providing services on its behalf under this Contract shall obtain and maintain in good standing all applicable accreditation(s), licenses and certificates required by the DHHS policy or law, including but not limited to licensure required by all appropriate agencies and/or Boards. The Provider and its agents providing services on the Provider's behalf under this Contract shall continuously, during the term of this Contract, meet all credentialing and privileging/competency standards as described in this Contract, the Operations Manual or as required by law, policy or regulation.

2.2 Service Record Compliance for Providers. Provider shall maintain a Service Record for each individual served in accordance with the Service Records standards set forth by state or federal law, Division's regulation or DHHS policy. The original Service Record related to services provided in accordance with this Contract shall be accessible for review for the purpose of monitoring services rendered, financial audits by third party payers and research and evaluation. Service records shall be retained for the duration and the format prescribed by Area Authority/County Program and by State and Federal law, regulation and policy. If for any reason Provider can no longer maintain the Service Record, Provider will contact the Area Authority/County Program staff member responsible for Service Records to facilitate resolution. Upon request, Provider shall provide data about individuals for the research and study to the Area Authority/County Program as permitted or required by DHHS and applicable Federal law. Upon request, Provider shall provide Service Records information about consumers referred by the Area Authority/County Program for Quality Assurance and Utilization Management purposes of the Area Authority/County Program.

2.3 Rights of Individuals. Provider shall conduct activities in a manner that shall deter, prevent, and avoid abuse, neglect, and/or exploitation of individuals in its care and to ensure compliance with all DHHS and Federal requirements and in accordance with the policies of Area Authority/County Program. The Provider agrees to maintain policies, procedures and monitoring as required in the DHHS Client Right's policy, the Operations Manual and the policies of Area Authority/County Program.

2.4 Adverse Selection. Provider shall be prohibited from arbitrarily declining, refusing to serve or ejecting consumers for the covered services under this Agreement. In the

event that Provider declines a referral, refuses to serve or ejects a specific consumer, Provider shall give Area Authority/County Program specific reason for the decline, refusal or denial. In all cases of adverse selection, Provider must provide timely reasons, and where applicable, notice to ensure that continuity of care can be optimized. Area Authority/County Program may consider information regarding adverse selection in its evaluation of Provider.

2.5 Service Coordination. Continuity of care is expected for all individuals served under this Contract. In an effort to improve the coordination of supports and services within the Area Authority/County Program's community of providers, Provider agrees to use good faith efforts to coordinate supports and services with other Provider participants, Carolina Access and other primary care providers for all individuals served under this Contract. The Provider shall obtain appropriate client authorizations and consents to release or exchange information. The Provider shall endeavor to participate in team meetings and/or community collaborations and communicate regularly with other providers regarding mutual cases. The primary service provider who engages an Independent Practitioner (a directly enrolled clinician providing outpatient therapy) to serve consumers receiving benefits will maintain a contract with the Independent Practitioner to ensure care coordination. Providers who act as the clinical home such as those delivering Community Support, Community Support Team or Targeted Case Management Services must either provide or arrange and coordinate appropriate psychiatric services when consumers need them.

2.6 Quality Management. Provider of benefits shall conduct a quality management program in accordance with the DHHS policies and agrees to provide evidence of assessment of quality of care and best practices, effectiveness and satisfaction with services to the Area Authority/County Program upon request. Provider shall abide by the treatment protocols, requirements for person-centered planning and implement evidence-based practices as defined and adopted by the Division of MH/DD/SA and any subsequent revisions. Provider shall ensure that corrective action is taken on a timely basis to address problems found through the quality management process.

2.7 Clinical Outcome Measures: At a minimum, the benefit Provider shall complete the NC-TOPPS for the designated populations as well as all other Division of MH/DD/SA required outcomes assessments on clients admitted during each calendar quarter in accordance with Department guidelines and any subsequent changes thereto. (See Operations Manual). The Area Authority/County Program shall define the guidelines for obtaining and submitting the outcomes data and convey this information to Provider. The appropriate outcome instrument to be used for a specific client will be dependent upon the age and primary disability category of the client and any changes made to these requirements by the Department of Health and Human Services through any outcome transition plan with the Area Authority/County Program. Providers shall submit outcome instruments required by the Division of MH/DD/SAS in an amount, manner and schedule as described in the Operations

Manual and as referenced in the most recent version of the Client Data Warehouse (CDW).

2.8 Incident Reporting. Provider shall report and respond to all client incidents as required under State and Federal law, rules and regulations. Incidents shall be reported in the manner prescribed and on a form provided by the Secretary of the DHHS. (See Operations Manual)

2.9 Reports of Regulatory Authorities. Copies of surveys, reviews and/or audits, performed by primary accrediting or regulatory authorities, of Provider and utilized to confirm operational compliance of Provider and require corrective action on the part of Provider shall be provided to the Area Authority/County Program upon receipt to the Provider.

2.10 Suspension or Debarment. Provider certifies by signing this Contract that neither it nor its agents have been suspended or debarred by any applicable governmental authority from conducting any business or activities contemplated by this Contract whether under current corporate name or any additional name or former name, including the current or former name of a division, department, program or subsidiary.

2.11 Liability Insurance. Provider, prior to service delivery, shall provide proof of and continuously maintain insurance coverage with a carrier authorized to do business in North Carolina, or maintain equivalent coverage under a self-insurance program that is approved by the North Carolina Department of Insurance. Liability coverage may be on an occurrence basis or claims-made basis. If the policy is on a claims-made basis, an extended reporting endorsement (tail coverage) shall also be provided for a period of not less than three (3) years after the end of the term of this Contract, or an endorsement shall be provided for continued liability coverage with a retroactive date on or before the beginning of the term of this Contract or any prior Contract between Provider and Area Authority/County Program.

Provider shall acquire and maintain:

a) Commercial General Liability:

Provider shall maintain bodily injury and property damage liability coverage as shall protect Provider and any approved subcontractor performing work under this Contract from claims of bodily injury or property damage which arise from operations of this Contract whether such operations are performed by Provider, any subcontractor or anyone directly or indirectly employed by either. The amounts of such insurance shall not be less than $1,000,000.00 each occurrence and $3,000,000.00 in the annual aggregate unless Provider, with prior written approval of Area Authority/County Program, names the Area Authority/County Program as an additional insured, in which case limits of no less than

$1,000,000.00 each occurrence and $1,000,000.00 in the annual aggregate would be acceptable.

b) Professional Liability (where applicable):

Provider shall maintain such professional liability insurance coverage as shall protect the Provider from its failure to conform to the professional standard of care required under applicable law and under this Contract. The limits of liability shall be not less than $1,000,000.00 per occurrence and $3,000,000.00 in the annual aggregate. The Provider's professional liability insurance policy shall name the Area Authority/County Program as additional insured. An original, signed, in force Certificate of Insurance for such coverage shall be provided to the Area Authority/County Program upon execution of this Contract and throughout the duration of this Contract as insurance expires.

c) Automobile Liability:

Fleet vehicles, privately owned cars or hired cars utilized in the transport of consumers shall be insured against loss in an amount not less than $500,000.00 bodily injury each person, each accident, and $500,000.00 for property damage and $500,000.00 uninsured /under insured motorist; and $5,000.00 medical payment.

d) Worker's Compensation and Occupational Disease Insurance:

Provider shall meet the statutory requirements of the State of North Carolina for Worker Compensation and Occupational Disease Insurance, currently $100,000.00 per accident limit, $500,000.00 disease per policy limit, $100,000.00 disease each employee limit, providing coverage for employees and owner.

e) Certificates of Insurance:

The Provider agrees to notify the Area Authority by telephone and by providing written notice within five (5) days after receipt of information that the insurance carrier either intends to amend or terminate a policy or has amended or terminated any insurance policy providing the coverage referred to above. If Provider changes insurance carriers during the performance period of this Contract, Provider shall provide evidence to the Area Authority within five (5) days. Subcontractors, as part of the approval process by the Area Authority/County Program, must be required by Provider to meet all the insurance requirements of this Contract, including providing the Area Authority/County Program with certificates of such insurance. Nonetheless, this does not relieve Provider from maintaining full coverage as well.

2.12 Federal Requirements. Provider shall comply with all governmental requirements applicable to the services being provided and to its operations, including, but not

limited to the Certification Regarding Environmental Tobacco Smoke: Certification Regarding Lobbying: Certification Regarding Drug-Free Workplace Requirements: and Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transactions. (See Appendix A, B, C and D)

2.13 Clinical Information Data Submission. Providers that are authorized to conduct an assessment of a referred individual will submit all required data elements electronically within 5 calendar days of the last assessment session to the Area Authority/County Program, using the protocol(s) and formats described in the Operations Manual. Provider shall establish review procedures to ensure that a minimum of 90 percent of all elements for each record are complete and accurate and a minimum of 85 percent of all elements for each record are coded as something other than "Other" or "Unknown" within 30 days of first submission.

2.14 First Responder for Crisis/Emergency. A Provider delivering a service with defined first responder responsibilities or who are designated in the Person Centered Plan (PCP) (which will include a comprehensive crisis plan) shall act as first responder to individuals referred by Area Authority/County Program if and when the individual and/or a member of their support system initiates contact for assistance involving a psychiatric crisis or emergency. Only those individuals whose distress represents a clear and present danger to self or others, and/or those individuals whose level of distress is not alleviated following reasonable efforts, shall be referred to Area Authority/County Program's crisis service. Provider shall notify the individual and his/her support system of the process for accessing crisis/emergency services 24 hours a day, 7 days a week, 365 days a year, both orally and in writing at initial contact. The notification shall include contact information for an alternate source of assistance in the eventuality that Provider is not available. Crisis services do not require prior authorization from Area Authority/County Program.

2.15 Utilization Management Requirements. Provider shall abide by clinically sound criteria. Provider shall seek authorization prior to service delivery and provide accurate and thorough information requested so that service provision is not unduly delayed or disrupted.

2.16 Preservation of DHHS Public Funds. Provider shall demonstrate good faith efforts to seek alternative and/or supplemental sources of financing so as to reduce dependency on government monies. Providers offering mental health and/or substance abuse services on an outpatient basis shall demonstrate good faith efforts to seek and/or maintain membership on major commercial insurance panels, including but not limited to Blue Cross/Blue Shield.

2.17 Response to Survivors of Disasters and other Hazards, If designated by Area Authority/County Program, Provider, under the direction of the Area Authority/County Program and in coordination with the local Emergency Management agency(ies), shall deploy behavioral health disaster responders to

deliver behavioral health disaster services to survivors and other responders within the counties served by Area Authority/County Program. Behavioral health disaster services may be required at the site of a disaster, in emergency shelters, on the telephone/TTY machine, and other sites in which other disaster response agencies provide information or services to survivors and responders (e.g., FEMA Disaster Application Centers, emergency medical intervention, decontamination or quarantine sites). When it is determined that survivors or other disaster responders are in need of longer term mental health, developmental disabilities, and/or substance abuse services, Provider's behavioral health disaster responders shall refer such persons in need to the Area Authority/County Program or its designee for further assistance.

2.18 Training and Technical Assistance.. The Area Authority/County Program reserves the right to charge the usual and customary fee for additional staff attendance or scheduling additional trainings to meet Provider demand. The Area Authority/County Program shall also mandate Provider attendance at selected Clinical Sessions of which the Provider bears the cost, whether Area Authority/County Program sponsored or offered by outside Parties. The Provider shall also bear the cost of all trainings related to licensure or accreditation activities. The Provider must be able to demonstrate to Area Authority/County Program its application of training information received in the delivery of services and in compliance with the provisions of this Contract.

2.19 Coordination of Benefits. Provider agrees to assist in the coordination of each individual's health care benefits so as to avoid undue delay in the provision of service and to ensure that Federal, state and local funding shall be used only if and when other sources of first and third Party payment have been exhausted. Providers shall make every reasonable effort to verify all insurance and other third Party benefit plan details during first contact, so that persons are directed to appropriate Providers, and to comply with North Carolina law. Where available, Provider is required to bill a consumer's private insurance. During an emergency, Provider shall provide the necessary services and then assist to coordinate payment.

2.20 Compliance with Title VI and VII. Provider shall comply with Title VI and VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act of 1990 (ADA), and all requirements imposed by Federal regulations, rules, and guidelines issued pursuant to these Titles for both personnel employed and individuals served.

ARTICLE III
MUTUAL RIGHTS AND OBLIGATIONS OF BOTH PARTIES

3.1 Health Insurance Portability and Accountability Act (HIPAA). The Provider and the Area Authority/County Program shall comply with current HIPAA privacy and security rules and regulations as in effect from time to time and each Party shall provide evidence to the other of this compliance upon request as embodied in Attachment B titled Business Associate or Qualified Service Organization Contract and 42 CFR, Part 2. This includes, but is not limited to, the responsibility of each Party to determine when it is exchanging non-treatment-related information with the other Party or with other entities, in order to obtain or perform a business service related to the performance of this Contract, and to implement a specific business Contract with the other Party or other entity if so. The Parties hereto specifically agree to amend this Contract on a timely basis as necessary to comply with any and all laws relating to privacy and/or security of healthcare information, including the Health Insurance Portability and Accountability Act of 1996 (45 CFR Parts 160, 162 & 164 and 42 CFR, part 2) and any subsequent modifications thereof.

3.2 Confidentiality. Provider and Area Authority/County Program shall protect the confidentiality of any and all individuals and will not discuss, transmit, or narrate in any form other information, medical or otherwise, received in the course of providing services hereunder, except as authorized by the individual, his legally responsible person, or as otherwise permitted or required by law. The Provider and Area Authority/County Program shall, in addition, meet all confidentiality requirements promulgated by any applicable governmental authority.

3.3 Governing Laws. The laws of the State of North Carolina shall govern the validity and interpretation of the provisions, terms, and conditions of this Contract. Venue over any action arising out of this Contract shall lie only in the county(s) in Area Authority/County Program's catchment area.

3.4 Entire Contract Modification. This Contract, along with the Operations Manual and other standards or documents specifically incorporated herein, constitutes the entire understanding of the Parties and this Contract shall not be altered, amended, or modified except by a Contract in writing, properly executed by the duly authorized officials of both Parties.

3.5 Dispute Resolution. The Parties shall first attempt to resolve any disagreement between them through the DHHS Appeals Process. However, a failure to do so shall not operate as a failure to exhaust administrative remedies.

3.6 Invalid Provisions. If any term, provision, or condition of this Contract is found to be illegal, void, or unenforceable by a court of competent jurisdiction, the rest of

this Contract shall remain in full force and effect. The invalidity or unenforceability of any term or provision of this Contract shall in no way affect the validity or enforceability of any other term or provision.

3.7 Hold Harmless. The Area Authority/County Program and Provider agree to each be solely responsible for their own acts or omissions in the performance of each of their individual duties hereunder, and shall be financially and legally responsible for all liabilities, costs, damages, expenses and attorney fees resulting from, or attributable to any and all of their individual acts or omissions. No Party shall have any obligation to indemnify the other, and/or its agents, employees and representatives.

3.8 Independent Contractor. This Contract is not intended and shall not be construed to create the relationship of agent, servant, employee, partnership, joint venture, or association between Provider and Area Authority/County Program, their employees, partners, or agents, but rather is a Contract by and among independent contractors; provided this shall not be construed to preclude Provider from utilizing service Contracts for provision of professional services in place of employment agreement.

3.9 Subcontracting. Provider shall not subcontract or assign any of the services contemplated under this Contract without obtaining prior written approval from the Area Authority/County Program. Any approved subcontracts or assignments for program delivery shall be subject to all conditions of this Contract. The Area Authority/County Program may assign its rights and obligations under this Contract without approval of providers.

3.10 Non-Exclusivity. This Contract is not exclusive. Area Authority/County Program and Providers have the right to enter into a similar Contract with any other Area Authority/County Program and/or other providers at any time.

3.11 Mergers, Name Changes and Acquisitions and Changes in Ownership or Control. Both parties shall be responsible for notification to the Division of Facility Services and to Area Authority/County Program of all such changes when required to do so. Each Party shall promptly notify the other in writing regarding any merger, name change, acquisition of another company, and change in ownership or control. The surviving entity shall be bound by all the terms and conditions of this Contract.

3.12 Conflict of Interest. Provider and Area Authority/County Program will comply with all applicable laws regarding Conflict of Interest.

3.13 Response Time. Both parties shall implement policies, procedures, performance standards and monitoring and shall consistently provide adequate staffing and scheduling to ensure compliance with the Division of MH/DD/SA Services' "immediacy of need protocol" such that: 1. Individuals in emergency status, meaning a situation which threatens the health, safety or welfare of the individual

and/or of others, shall result in a face-to-face assessment which shall commence no later than two hours from notification to either Party, 2. Individuals in urgent status, meaning their situation is likely to escalate into an emergency, must be seen face-to-face (assessment and/or services) within 48 hours of first notification, 3. Individuals with routine needs must be seen face-to-face (assessment and /or services) within seven (7) calendar days of first notification, and 4. Individuals released/discharged from a state hospital or institution must be seen within 5 days of release.

ARTICLE IV
TERM AND TERMINATION

4.1 Term The term of this Contract shall be for a period commencing.

4.2 Provider Termination. This Contract may be terminated at any time by the Provider after ninety (90) days written notice of termination.

4.3 Area Authority/County Program Termination. Area Authority/County Program may immediately terminate this Contract for cause. The cause for termination shall be documented in writing presented to the Provider detailing the grounds for termination. Prior to termination of this Contract for cause, such as repeated non-performance of obligations without corrective action, violations of professional standards or the commission of unlawful acts, the Area Authority/County Program may elect to halt or restrict commerce between the parties. The Quality Management Committee shall make such decisions and the Provider shall be notified in writing of the rationale and specifications of the suspension and the conditions that must be met to end the suspension. Area Authority/County Program may terminate this Contract in its discretion if Provider is acquired, merged or experiences a change in ownership or control.

4.4 Notice Either Party may at any time change its address for notification purposes by mailing a notice to the other Party at the address designated by that Party. The new address shall be effective on the date specified in such notice, or if no date is specified, on the tenth (10th) day following the date such notice is received.

4.5 Option for Limited Renewal: The Area Authority/County Program may, by written notice to the Provider executed by the Area or Program Director, extend the term of this Contract.

ARTICLE V
FINANCIAL REQUIREMENTS FOR PROVIDERS OF STATE FUNDED SERVICES

5.1 Claims/Invoice Review. Area Authority/County Program shall review claims within eighteen (18)calendar business days after receipt and shall notify Provider within that timeframe if the claims/invoice or portions of the claims/invoice are denied or if further information is necessary. Area Authority/County Program shall pay approved or undisputed portions of the claims/invoice for services performed by Provider within thirty (30) calendar days after approval. Such payment constitutes full and final payment of approved claims/invoice.

5.2 Reimbursement Schedule. The amount and conditions of reimbursement for Covered Services rendered by the Provider to be paid to the Provider is set forth in **Attachment A.**

5.3 Purchase of Equipment. If this Contract includes payment for equipment purchased with non unit-cost reimbursement funds (non-UCR), such as start up or special purpose funding, title to the assets purchased under this Contract in whole or in part rests with the Area Authority/County Program so long as the Provider continues to provide the services which are named in this Contract. If such services are discontinued, disposition of the assets shall occur as approved by the Division of MH/DD/SAS and in accordance with North Carolina law.

5.4 Billing: Provider is responsible for billing for all first and third Party payment.

5.5 Schedule of Fees. Provider shall be responsible for the adoption, assessment, collection, and disposition of fees in accordance with all applicable law.

5.6 Submission of Invoices. Provider shall submit an invoice to the Area Authority/County Program within sixty (60) days of the date of service or sooner if required by IPRS timely filing deadlines. All invoices submitted by the Provider to Area Authority/County Program after sixty (60) days will be excluded from the timelines governing the prompt pay provisions.

5.7 Recovery of Funds/Paybacks : Unless specifically approved otherwise in writing by the Area Authority/County Program, Provider shall pay back within sixty (60) days to Area Authority/County Program the amount paid by Area Authority/County Program to Provider for all non-compliant events or services.

5.8 Financial Audit: Provider shall adhere to Generally Accepted Accounting Principles. When required and requested, Provider shall make available to Area Authority/County Program its accounting records relating to services provided to or on behalf of Area Authority/County Program under this Contract for the purpose of audit by the DHHS for Federal authorities or by Area Authority/County Program.

Provider, when required by law or in accordance with the annual Contract between the DHHS and Area Authority/County Program, shall have an annual audit by an independent certified public accountant (CPA). If required, a copy of the independent audit shall be forwarded to:

Office of the DHHS Auditor
300 North Salisbury Street
Raleigh, NC 27603-5903

5.9 Budget Revisions and Fund Balance. This Contract is a purchase of service Contract.

5.10 Effect of Termination. All payments provided herein shall be adjusted so as not to exceed the amount due for services actually rendered prior to the date of termination. If advance payments have been made for covered services not provided as of the date of termination, Provider shall promptly refund all excess funds paid. If additional payments are due from Area Authority/County Program, said payments shall be made only after receipt of final invoice and report. Termination of the Contract may result in the loss of endorsement within the catchment area of the Area Authority/County Program.

IN WITNESS WHEREOF, each Party has caused this Contract to be executed in multiple copies, each of which shall be deemed an original, as the act of said Party. Each individual signing below warrants he/she is duly authorized by the Party to sign this Contract and to bind the Party to the terms and conditions of this Contract.

Provider's Federal ID No. _____

_____

DULY AUTHORIZED OFFICIAL **DATE**

_____

PRESIDENT, BOARD OF DIRECTORS **DATE**

Area Authority/County Program name/address

_____

DULY AUTHORIZED OFFICIAL **DATE**

_____

FINANCE OFFICER **DATE**

March 9, 2006

ATTACHMENT A
(Each Area program designs**)**

LIST OF SERVICES

(Provider Name)

SERVICE	SERVICES	EFFECTIVE DATES
*Ambulatory Detoxification		
*Assertive Community Treatment Team – ACTT		
Child and Adolescent Day Treatment (MH/SA)		
*Community Support – Adults (MH/SA)		
*Community Support – Children/Adolescents (MH/SA)		
*Community Support Team – CST (MH/SA)		
*Developmental Therapy Services		
*Diagnostic Assessment (MH/DD/SA)		
*Inpatient Hospital Psychiatric Treatment (MH)		
*Inpatient Hospital Substance Abuse Treatment		
*Intensive In-Home Services		
*Medically Supervised or ADATC Detoxification/Crisis Stabilization		
*Mobile Crisis Management (MH/DD/SA)		
*Multisystemic Therapy – MST		
*Non-Hospital Medical Detoxification		
*Psychiatric Residential Treatment Facility – PRTF		
*Psychosocial Rehabilitation – PSR		
*Social Setting Detoxification		
*Substance Abuse Comprehensive Outpatient Treatment Program		
*Substance Abuse Halfway House		
*Substance Abuse Intensive Outpatient Program		
*Substance Abuse Medically Monitored Community Residential Treatment		
*Substance Abuse Non-Medical Community Residential Treatment		
*Targeted Case Management for Individuals with Developmental Disabilities		
Facility Based Crisis Program		
Opioid Treatment		
Personal Care		
CAP Services		

March 9, 2006

ATTACHMENT B

BUSINESS ASSOCIATE OR QUALIFIED SERVICE ORGANIZATION CONTRACT

This Contract is made effective the 1st of July 2006, by and between Provider, hereinafter referred to as "Covered Entity" and Area Authority/County Program hereinafter referred to as "Business Associate or Qualified Service Organization", (individually, a "Party" and collectively, the "Parties").

WITNESSETH*:*

WHEREAS, Sections 261 through 264 of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, known as "the Administrative Simplification provisions," direct the Department of Health and Human Services to develop standards to protect the security, confidentiality and integrity of health information; and

WHEREAS, pursuant to the Administrative Simplification provisions, the Secretary of Health and Human Services has issued regulations modifying 45 CFR Parts 160 and 164 (the "HIPAA Security and Privacy Rule"); and

WHEREAS, the Parties wish to enter into or have entered into an arrangement whereby Business Associate or Qualified Service Organization will provide certain services to Covered Entity, and, pursuant to such arrangement, Business Associate or Qualified Service Organization may be considered a "Business Associate or Qualified Service Organization" of Covered Entity as defined in the HIPAA Security & Privacy Rule and 42 CFR, Part 2 (the Contract evidencing such arrangement is entitled Purchase of Service Contract dated July 1, 2006 and is hereby referred to as the "Arrangement Contract"); and

WHEREAS, Business Associate or Qualified Service Organization may have access to Protected Health Information (as defined below) in fulfilling its responsibilities under such arrangement;

I. DEFINITIONS

Except as otherwise defined herein, any and all capitalized terms in this Section shall have the definitions set forth in the HIPAA Privacy Rule and 42 CFR, Part 2. In the event of an inconsistency between the provisions of this Contract and mandatory provisions of the HIPAA Privacy Rule and 42 CFR, Part 2, as amended, the HIPAA Security & Privacy Rule and 42 CFR, Part 2 shall control. Where provisions of this Contract are different than those mandated in the HIPAA Security & Privacy Rule and 42 CFR, Part 2, but are nonetheless permitted by the HIPAA Security & Privacy Rule and 42 CFR, Part 2, the provisions of this Contract shall control.

The term "Protected Health Information" means individually identifiable health information including, without limitation, all information, data, documentation, and materials, including without limitation, demographic, medical and financial information, that relates to the past, present, or future physical or mh/dd/sa condition or that relates to the past, present or future physical or mental health or condition of an individual; with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Business Associate or Qualified Service Organization acknowledges and agrees that all Protected Health Information that is created or received by Covered Entity and disclosed or made available in any form, including paper record, oral communication, audio recording, and electronic display by Covered Entity or its operating units to Business Associate or Qualified Service Organization or is created or received by Business Associate or Qualified Service Organization on Covered Entity's behalf shall be subject to this Contract.

II. CONFIDENTIALITY REQUIREMENTS

(a) Business Associate or Qualified Service Organization agrees:
(i) To use or disclose any Protected Health Information solely: (1) for meeting its obligations as set forth in any Contracts between the Parties evidencing their business relationship or (2) as required by applicable law, rule or regulation, or by accrediting or credentialing organization to whom Covered Entity is required to disclose such information or as otherwise permitted under this Contract, the Arrangement Contract (if consistent with this Contract and the HIPAA Security & Privacy Rule and 42 CFR, Part 2), or the HIPAA Security & Privacy Rule and 42 CFR, Part 2, and (3) as would be permitted by the HIPAA Security & Privacy Rule and 42 CFR, Part 2 if such use or disclosure were made by Covered Entity;
(ii) At termination of this Contract, the Arrangement Contract (or any similar documentation of the business relationship of the Parties), or upon request of Covered Entity, whichever occurs first, if feasible, Business Associate or Qualified Service Organization will return or destroy all Protected Health Information received from or created or received by Business Associate or Qualified Service Organization on behalf of Covered Entity that Business Associate or Qualified Service Organization still maintains in any form and retain no copies of such information, or if such return or destruction is not feasible, Business Associate or Qualified Service Organization will extend the protections of this Contract to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information not feasible; and
(iii) To ensure that its agents, including a subcontractor, to whom it provides Protected Health Information received from or created by Business Associate or Qualified Service Organization on behalf of Covered Entity, agrees to the same restrictions and conditions that apply to Business Associate or Qualified Service Organization with respect to such information and agrees to implement reasonable and appropriate safeguards to protect any of such information which is electronic protected health information. In addition, Business Associate or Qualified

Service Organization agrees to take reasonable steps to ensure that its employees' actions or omissions do not cause Business Associate or Qualified Service Organization to breach the terms of this Contract.

(b) Notwithstanding the prohibitions set forth in this Contract, Business Associate or Qualified Service Organization may use and disclose Protected Health Information as follows:
(i) If necessary, for the proper management and administration of Business Associate or Qualified Service Organization or to carry out the legal responsibilities of Business Associate or Qualified Service Organization, provided that as to any such disclosure, the following requirements are met:
    (A) The disclosure is required by law; or
    (B) Business Associate or Qualified Service Organization obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies Business Associate or Qualified Service Organization of any instances of which it is aware in which the confidentiality of the information has been breached;
(ii) for data aggregation services, if to be provided by Business Associate or Qualified Service Organization for the health care operations of Covered Entity pursuant to any Contracts between the Parties evidencing their business relationship. For purposes of this Contract, data aggregation services means the combining of Protected Health Information by Business Associate or Qualified Service Organization with the protected health information received by Business Associate or Qualified Service Organization in its capacity as a Business Associate or Qualified Service Organization of another covered entity, to permit data analyses that relate to the health care operations of the respective covered entities.

(c) Business Associate or Qualified Service Organization will implement appropriate safeguards to prevent use or disclosure of Protected Health Information other than as permitted in this Business Associate or Qualified Service Organization will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any electronic protected health information that it creates, receives, maintains, or transmits on behalf of covered entity as required by the HIPAA Security and Privacy Rule and 42 CFR, Part 2.

(d) The Secretary of Health and Human Services shall have the right to audit Business Associate or Qualified Service Organization's records and practices related to use and disclosure of Protected Health Information to ensure Covered Entity's compliance with the terms of the HIPAA Security & Privacy Rule and 42 CFR, Part 2.

(e) Business Associate or Qualified Service Organization shall report to Covered Entity any use or disclosure of Protected Health Information which is not in compliance with the terms of this Contract of which it becomes aware. Business Associate or Qualified Service Organization shall report to Covered Entity any security incident of which it becomes aware. For purpose of this Contract, Security incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system. In addition, Business Associate or Qualified Service Organization agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate or Qualified Service Organization of a use or disclosure of Protected Health Information by Business Associate or Qualified Service Organization in violation of the requirements of this Contract.

III. AVAILABILITY OF PHI

Business Associate or Qualified Service Organization agrees to make available Protected Health Information to the extent and in the manner required by Section 164.524 of the HIPAA Security & Privacy Rule and 42 CFR, Part 2. Business Associate or Qualified Service Organization agrees to make Protected Health Information available for amendment and incorporate any amendments to Protected Health Information in accordance with the requirements of Section 164.526 of the HIPAA Security & Privacy Rule and 42 CFR, Part 2. In addition, Business Associate or Qualified Service Organization agrees to make Protected Health Information available for purposes of accounting of disclosures, as required by Section 164.528 of the HIPAA Security & Privacy Rule and 42 CFR, Part 2.

IV. TERMINATION

Notwithstanding anything in this Contract to the contrary, Covered Entity shall have the right to terminate this Contract and the Arrangement Contract immediately if Covered Entity determines that Business Associate or Qualified Service Organization has violated any material term of this Contract. If Covered Entity reasonably believes that Business Associate or Qualified Service Organization will violate a material term of this Contract and, where practicable, Covered Entity gives written notice to Business Associate or Qualified Service Organization of such belief within a reasonable time after forming such belief, and Business Associate or Qualified Service Organization fails to provide adequate written assurances to Covered Entity that it will not breach the cited term of this Contract within a reasonable period of time given the specific circumstances, but in any event, before the threatened breach is to occur, then Covered Entity shall have the right to terminate this Contract and the Arrangement Contract immediately.

V. MISCELLANEOUS

Except as expressed herein by DHHS or the HIPAA Security & Privacy Rule and 42 CFR, Part 2, the Parties to this Contract do not intend to create any rights in any third

Parties. The obligations of Business Associate or Qualified Service Organization under this Section shall survive the expiration, termination, or cancellation of this Contract, the Arrangement Contract and/or the business relationship of the Parties, and shall continue to bind Business Associate or Qualified Service Organization, its agents, employees, contractors, successors, and assigns as set forth herein.

This Contract may be amended or modified only in writing signed by the Parties. No Party may assign its respective rights and obligations under this Contract without the prior written consent of the other Party. None of the provisions of this Contract are intended to create, nor will they be deemed to create any relationship between the Parties other than that of independent Parties contracting with each other solely for the purposes of effecting the provisions of this Contract and any other Contracts between the Parties evidencing their business relationship. This Contract will be governed by the laws of the DHHS of North Carolina. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

The Parties agree that, in the event that any documentation of the arrangement pursuant to which Business Associate or Qualified Service Organization provides services to Covered Entity contains provisions relating to the use or disclosure of Protected Health Information which are more restrictive than the provisions of this Contract, the provisions of the more restrictive documentation will control. The provisions of this Contract are intended to establish the minimum requirements regarding Business Associate or Qualified Service Organization's use and disclosure of Protected Health Information.

In the event that any provision of this Contract is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions of this Contract will remain in full force and effect. In addition, in the event a Party believes in good faith that any provision of this Contract fails to comply with the then-current requirements of the HIPAA Security & Privacy Rule and 42 CFR, Part 2, such Party shall notify the other Party in writing. For a period of up to thirty days, the Parties shall address in good faith such concern and amend the terms of this Contract, if necessary to bring it into compliance. If, after such thirty-day period, the Contract fails to comply with the HIPAA Security & Privacy Rule and 42 CFR, Part 2, then either Party has the right to terminate upon written notice to the other Party.

IN WITNESS WHEREOF, the Parties have executed this Contract as of the day and year written above.

COVERED ENTITY: (Provider)	*BUSINESS ASSOCIATE OR QUALIFED SERVICE ORGANIZATION:*
By: _____	*By:* _____
Title: _____	*Title:* _____

ATTACHMENT C

CORE PERFORMANCE INDICATORS FOR PROVIDERS OF MH/DD/SA SERVICES

1. Providers shall be responsible for full participation in an Area Authority/County Program monitoring/review process that includes the Division of MH/DD/SA Confidence Assessment Criteria and the Local Monitoring discussion guide. Frequency of reviews and corrective requirements are determined by demonstration of acceptable compliance with quality indicators and scores from the Confidence Assessment.

2. 100% of all Level I Incidents as defined by the NC Division of MH/DD/SAS shall be recognized, adequately responded to, and reported/documented internally by the Provider, and reported in aggregate form quarterly to the Area Authority/County Program.

3. At least 85% of all Level II Incidents as defined by the NC Division of MH/DD/SAS shall be recognized, adequately responded to, and reported to the Area Authority/County Program and the Department within 72 hours via the *DHHS Incident & Death Form*. An aggregate total for the quarter will be part of the Provider's quarterly report to the Area Authority/County Program.

4. At least 85% of all Level III Incidents as defined by the NC Division of MH/DD/SAS shall be recognized, adequately responded to, and reported verbally immediately to the Area Authority/County Program, and in written form to the Area Authority/County Program and the Department within 72 hours via the DHHS Incident & Death Form. The Provider shall convene an incident review committee within 24 hours. Deaths that occur within 7 days of seclusion or restraint are reported immediately to the Area Authority/County Program. An aggregate total for the quarter will be part of the Provider's quarterly report to the Area Authority/County Program.

5. Providers shall implement policies, procedures, and practices to attempt to achieve 0% client rights violations. 100% of all substantiated client rights violations shall be reported through the Incident reporting process to the Customer Services/Consumer Affairs Unit of the Area Program/County Program Quality Management Department, and show evidence of being acted upon.

6. 100% of quality of care issues, as noted through Area Authority monitoring, shall promptly begin to be addressed through the development and initiation of a corrective action plan submitted for approval to the Area Authority/County Program within the

time limits specified in the Area Authority/County Program's Quality Management Plan.

7. A representative sample of consumers shall be given the opportunity to express their *perception of satisfaction* for services received through the implementation of an empirical process no less often than twice a year. Survey results are submitted to the Area Authority/County Program. Providers may meet this requirement by full participation in the Area Authority/County Program's Quarterly Consumer Satisfaction Survey. The Provider is also required to participate in the Division of MH/DD/SAS's annual Consumer Satisfaction Survey.

8. When applicable, Providers shall meet no less than 85% of established time frames for initial face-to-face consumer contact (Emergent: within 2 hours; Urgent: within 48 hours; Routine: 7 calendar days.).

9. Providers shall meet 100% compliance with Operations Manual administration protocols for established Outcome Measures for each eligible consumer (NC-TOPPS, COIs). As applicable to the service population, Providers shall participate in the annual Core Indicators survey (DD consumers and families).

10. Providers shall demonstrate a Continuous Quality Improvement (CQI) process by identifying a minimum of 3 improvement projects acted upon per year. Projects and results will be reported to the Area Authority/County Program in any quarter of completion.

SPECIFIC SERVICE DELIVERY PERFORMANCE INDICATORS

The following subject headings may be used to issue specific guidance to Providers of certain services.

I. Financial
II. Staffing
III. Best Practice/Model Fidelity
IV. Definitions
V. Outcomes/Goals
VI. Reporting
VII. Administration/Management/Infrastructure
VIII. Collaboration
IX. Training
X. Program Development
XI. Monitoring Regulatory Updates
XII. Provider Community Responsibility
XIII. Professional Development
XIV. Committee Participation

March 9, 2006

APPENDIX A

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Certification for Contracts, Grants, Loans and Cooperative Contracts

Public Law 103-227, Part C-Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through DHHS or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or State Funded funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 per day and/or the imposition of an administrative compliance order on the responsible entity.

By signing and submitting this application, Provider certifies that it will comply with the requirements of the Act. Provider further agrees that it will require the language of this certification be included in any sub awards which contain provisions for children's services and that all sub grantees shall certify accordingly.

APPENDIX B

CERTIFICATION REGARDING LOBBYING
Department of Health and Human Services
Department of Mental Health, Developmental Disabilities and Substance Abuse Services

Certification for Contracts, Grants, Loans and Cooperative Contracts

Provider certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal Contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative Contract, and the extension, continuation, renewal, amendment, or modification of any Federal Contract, grant, loan, or cooperative Contract.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal Contract, grant, loan, or cooperative Contract, the undersigned shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all sub awards at all tiers (including subcontracts, sub grants, and Contracts under grants, loans, and cooperative Contracts) and that all sub recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

March 9, 2006

APPENDIX C

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS
Department of Health and Human Services
Department of Mental Health, Developmental Disabilities and Substance Abuse Services

I. By execution of this Contract Provider certifies that it will provide a drug-free workplace by:

A. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the Provider's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

B. Establishing a drug-free awareness program to inform employees about:

(1) The dangers of drug abuse in the workplace;
(2) The Provider's policy of maintaining a drug-free workplace;
(3) Any available drug counseling, rehabilitation, and employee assistance programs; and
(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

C. Making it a requirement that each employee be engaged in the performance of the Contract and be given a copy of the statement required by paragraph (A);

D. Notifying the employee in the statement required by paragraph (A) that, as a condition of employment under the Contract, the employee will:

(1) Abide by the terms of the statement; and
(2) Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction;

E. Notifying the Department within ten days after receiving notice under subparagraph (D)(2) from an employee or otherwise receiving actual notice of such conviction;

F. Taking one of the following actions, within 30 days of receiving notice under subparagraph (D)(2), with respect to any employee who is so convicted:

(1) Taking appropriate personnel action against such an employee, up to and including termination; or
(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, DHHS, or local health, law enforcement, or other appropriate agency; and

G. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (A), (B), (C), (D), (E), and (F).

The site(s) for the performance of work done in connection with the specific Contract are listed below:

1._____
(Street address) (City, county, state, zip code)
2._____
(Street address) (City, county, state, zip code)

Provider will inform the Department of any additional sites for performance of work under this Contract.

False certification or violation of the certification shall be grounds for suspension of payment, suspension or termination of grants, or government-wide Federal suspension or debarment (Section 4 CFR Part 85, Section 85.615 and 86.620).

APPENDIX D
CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY
AND VOLUNTARY EXCLUSION-LOWER TIER COVERED TRANSACTIONS
Department of Health and Human Services
Department of Mental Health, Developmental Disabilities and Substance Abuse Services

Instructions for Certification

1. By signing and submitting this proposal, the Provider is providing the certification set out below.
2. The certification in this clause is a material representation of the fact upon which reliance was placed when this transaction was entered into. If it is later determined that the Provider knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.
3. The Provider will provide immediate written notice to the person to which the proposal is submitted if at any time the Provider learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.
4. The terms "covered transaction", "debarred", "suspended", "ineligible", "lower tier covered transaction", "participant", "person", "primary covered transaction", "principal", "proposal", and "voluntarily excluded", as used in this clause, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations.
5. The Provider agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter any lower tier covered transaction with a person who is debarred, suspended, determined ineligible or voluntarily excluded from participation in this covered transaction unless authorized by the department or agency with which this transaction originated.
6. The Provider further agrees by submitting this proposal that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
7. A participant in a covered transaction may rely upon a certification of a Provider in a lower tier covered transaction that it is not debarred, suspended, ineligible, or voluntarily excluded from covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency of which it determines the eligibility of its principals. Each participant may, but is not required to, check the non-procurement List.
8. Nothing contained in the foregoing shall be construed to required establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that

which is normally possessed by a prudent person in the ordinary course of business dealings.

9. Except for transactions authorized in paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension, and/or debarment.

Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions

(1) The Provider certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.

(2) Where the Provider is unable to certify to any of the statements in this certification, such Provider shall attach an explanation to this proposal.